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RSC Policy Brief:
Medical Loss Ratios

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In light of proposals by House Democrats and several state Governors to regulate insurers' expenditures on administrative expenditures and profits, the RSC has prepared the following policy brief analyzing the issue.

Background: The term medical loss ratio refers to the percentage of health insurance premium costs used to pay medical claims, as opposed to overhead for various administrative expenses or surplus/profit for the insurance carrier. For example, a medical loss ratio of 70% indicates that 70 cents of every premium dollar is spent on claims for medical services, with 30 cents dedicated towards administrative expenses, marketing costs, related overhead, and any profit for the carrier. While the medical loss ratios of publicly-traded insurance carriers are available in filings with the Securities and Exchange Commission (SEC), privately-held and not-for-profit insurers often do not face similar public reporting and disclosure requirements.

Legislative History: In July 2007, Section 414 of H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act, proposed several reporting requirements and restrictions on Medicare Advantage (MA) plans with respect to their medical loss ratios. Specifically, the bill required MA plans to submit information to the Department of Health and Human Services (HHS) regarding overall expenses on medical claims, marketing and sales, indirect and direct administration, and any medical reinsurance. The Secretary would be required to publish this information annually.

In addition to the reporting requirements outlined above, the CHAMP Act also proposed punitive measures against MA plans which did not meet new federal requirements with respect to their medical loss ratios. Subsection (c) of Section 414 proposed sanctions for MA plans which did not spend at least 85% of payments received (both from the federal government and beneficiary premiums) on medical services: plans below the ratio for one year would receive a decrease in their funding rate, plans below the ratio for three years would be banned from enrolling new beneficiaries, and plans below the ratio for five years would be terminated from the Medicare

Advantage program. While the bill passed the House by a 225-204 vote, the Senate has yet to take up the measure.

Presidential and State Proposals: The actions proposed by House Democrats last year with respect to Medicare Advantage plans are consistent with the proposals advocated by the Democrat candidates for President. During her campaign, Sen. Hillary Rodham Clinton (D-NY) proposed an unspecified minimum medical loss ratio for insurers, because "premiums collected by insurers must be dedicated to the provision of high-quality care, not excessive profits and marketing."[1] Similarly, the health plan of Sen. Barack Obama (D-IL) dedicates a section of his platform to explaining why insurance carriers' "record profits" constitute "needless waste," and pledges that "in markets where the insurance business is not competitive enough, [the Obama] plan will force insurers to pay out a reasonable share of their premiums for patient care instead of keeping exorbitant amounts for profits and administration."[2] However, the plan does not specify what constitutes a "competitive" state insurance market, nor the level of a "reasonable" medical loss ratio.

In recent months, several state-based efforts to reform health care have incorporated proposals to regulate medical loss ratios by insurers. Proposals in California, Pennsylvania, New Mexico, Michigan, Illinois, and Wisconsin have all discussed setting a minimum medical loss ratio, often at 85%. While some states currently do impose minimum medical loss ratios, these are significantly lower than the proposed new standards; in some cases, minimum ratios are designed to ensure that the policy is a *bona fide* insurance product, rather than attempting to influence the structure of an insurance policy or the business model of an insurance carrier.

Medicare Advantage Reports: This week, the Government Accountability Office (GAO) released a report requested by Ways and Means Health Subcommittee Chairman Pete Stark (D-CA) regarding profit levels by Medicare Advantage plans. The report noted that in 2005, Medicare Advantage plans' actual profits were higher, and their medical and administrative expenditures lower, than originally projected before the start of the contract year. However, even the lower-than-expected percentage of revenue devoted to medical expenses—85.7%—exceeded the minimum loss ratio proposed by Congressional Democrats under the CHAMP Act.[3] GAO also conceded that the disparity between actual and projected expenses had no impact on the total payments made to Medicare Advantage plans.[4]

In response to the GAO report, the Centers for Medicare and Medicaid Services (CMS) pointed out that contract bids for Medicare Advantage plans in 2005 were submitted under a since-replaced bidding formula, and have since been subjected to more stringent actuarial standards with respect to the accuracy of the original projections—both of which would tend to cast doubts on the relevancy of the three-year-old data on the current Medicare Advantage program.

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[1] "American Health Choices Plan," available online at http://www.hillaryclinton.com/issues/healthcare/americanhealthchoicesplan.pdf (accessed March 11, 2008), p. 7.
[2] "Barack Obama's Plan for a Healthy America," available online at http://www.barackobama.com/issues/pdf/HealthCareFullPlan.pdf (accessed March 11, 2008), pp 9-10.
[3] "Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2005," Letter to Hon. Pete Stark, Report GAO-08-827R, (Washington, DC, Government Accountability Office, June 2008), available online at http://www.gao.gov/new.items/d08827r.pdf (accessed June 26, 2008), p. 5.
[4] Ibid., p. 8.

Additionally, the fact that nearly half of the "unexpected" profits arose from a single Medicare Advantage plan raises additional questions as to whether the disparity between projected and actual medical expenditures is a system-wide problem or a relatively confined anomaly.[5]

Some conservatives may view higher-than-projected profits for Medicare Advantage plans as consistent with the free-market principles that encourage companies—in this case, private health insurers—to improve efficiencies in the hope of generating improvements for their customers and a return to their investors. The fact that nearly half of Medicare Advantage beneficiaries were covered by plans with lower-than-expected administrative and non-medical expenses could suggest that plans took steps to reduce bureaucracies that made their delivery more efficient.[6] Moreover, to the extent that improved care management tools implemented by insurance carriers resulted in lower-than-expected medical expenditures for plans, conservatives may argue that allowing Medicare Advantage carriers to retain these profits is not only appropriate, but desirable.

Moreover, another GAO report released in February injected a note of caution regarding attempts to use headlines about Medicare Advantage plan profits to regulate medical loss ratios, noting that "there is no definitive standard for what a medical loss ratio should be."[7] In the February report, officials at CMS commented that some plans may consider certain care management services an administrative expense, while other plans may classify these costs as medical treatments. The fact that Health Maintenance Organizations (HMOs)—which are traditionally known for intensive care management techniques, and whose per-beneficiary costs are slightly lower than those for traditional fee-for-service Medicare—had the highest percentage of beneficiaries in plans under the 85% threshold ratio included in the CHAMP Act demonstrates the inherent difficulties in applying a single regulatory standard to all types of insurance.[8]

Conclusion: The issue of regulating medical loss ratios, although not as prominent as other elements of Democrat proposals for health care reform, nevertheless deserves scrutiny. An article in the journal *Health Affairs* concluded that medical loss ratios had little correlation to the quality of care provided by carriers; moreover, the article's discussion of the loss ratio as an inherently arbitrary measure dovetails with the unintended consequences of applying a one-size-fits-all standard for health insurance. For instance, individual insurance plans face higher administrative charges than group policies, because of the increased costs associated with selling policies on a person-to-person basis, as opposed to the hundreds or thousands of beneficiaries who obtain insurance through a single group employer. Additionally, regulating medical loss ratios may prompt some insurance carriers to stop offering high-deductible insurance plans—which, due to their smaller premiums, may have greater difficulty meeting a federally-imposed standard—thus diminishing the impact of Health Savings Accounts (HSAs), which have over the past few years helped slow the growth of health insurance premiums.

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[5] Ibid., pp. 11-14.
[6] Ibid., p. 6.
[7] "Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs," Report GAO-08-359 (Washington, DC, Government Accountability Office, February 2008), available online at http://www.gao.gov/new.items/d08359.pdf (accessed March 11, 2008), p. 32n.
[8] Ibid., pp. 27-28.

More broadly, some conservatives may be concerned that regulating medical loss ratios represents an effort by Democrats to impose price controls on the health insurance industry. Proposals such as those included in the CHAMP Act are unlikely to result in higher spending on medical claims, or lower profits for insurance companies; carriers could instead choose to reduce administrative costs in order to comply with a mandated medical loss ratio, resulting in additional delays for beneficiaries seeking to have their claims processed.

An alternative solution could lie in proposals for increased public transparency and disclosure of medical loss ratios. Applied evenly to for-profit and not-for-profit insurers alike, this information would allow consumers to make an informed choice, considering the percentage of premiums devoted to medical claims payment as one element among many when selecting an insurance policy. Although some policy-makers may find it politically expedient to criticize the profits of certain insurance carriers, many conservatives would greatly prefer the transparency of a free marketplace to heavy-handed government price controls.

For further information on this issue see:

- *Health Affairs Article: Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*

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